Washington State Department of Social & Health Services

Medical Assistance Administration
Division of Medical Management &
Division of Program Support

State of Washington
Department of Social and Health Services
Medical Assistance Administration

Managed Care Quality Strategy
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Produced by

Quality Assessment, Improvement, and Monitoring
&
Managed Care Contracting

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I. Introduction

The Balanced Budget Act (BBA) of 1997 requires each state Medicaid agency contracting with a Managed Care Organization (MCO) to develop and implement a written strategy for assessing and improving the quality[1] of managed care services (42 CFR.438.202). The strategy must comply with the provisions established by the Department of Health and Human Services (DHHS) issued in the Federal Register on June 14, 2002. The BBA also requires that the quality strategy either adopt DHHS protocols for independent external review of MCO compliance with Federal quality standards, released by DHHS February 11, 2003, or the protocols be consistent with them.

This document is the Washington State Medical Assistance Administration (MAA) Quality Strategy. It summarizes a systematic approach to planning, measuring, assessing and improving health care and services in MCOs, and describes methods for MAA compliance with Federal quality standards. The significance of a written strategy is that it provides a reference document and summary information to MAA leadership on the system MAA uses to measure and enforce material terms of the MCO contract. The information enables leadership to ensure agency activities align with Federal requirements and MAA and Department of Social and Health Services (DSHS) strategic plans.

II. Overview of the Medical Assistance Administration

DSHS is the single State agency designated to administer the Medicaid program under Title XIX of the Social Security Act (42 CFR 431.10). One of seven administrations in DSHS, MAA represents 44 percent of the DSHS $7 billion biennial budget.

Eleven programs within MAA administer health care coverage for low-income families, pregnant women, children, the elderly and persons with disabilities. The largest program is the Medicaid[2] program, which covers one-third of all children and more than 40 percent of all births in Washington. More than 900,000 people currently receive health care through these programs and over half (459,574) are enrolled in managed care. More than 80 percent of enrollees in managed care are under the age of nineteen.

[1] The definition on the CMS website is: The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person, or group of persons, locating the problem, correcting the problem, and then checking to see if what you did worked.

[2] Medicaid is a jointly funded Federal-State health insurance program for certain low-income and needy people.

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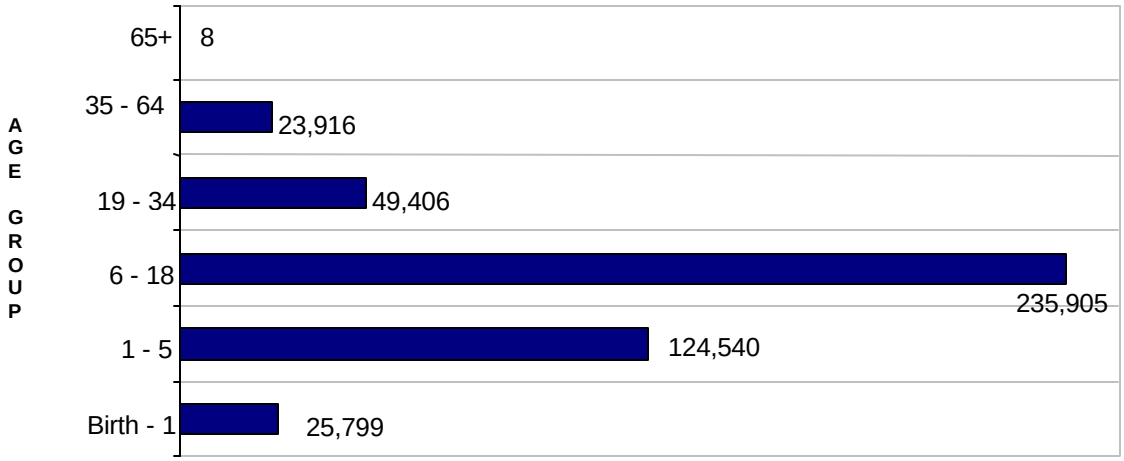
2002 Statewide Medicaid Managed Care Enrollment by Age Group



The MAA managed care program is called Healthy Options. The State Children's Health Insurance Program (SCHIP) and Basic Health Plus (BH+) programs are included in Healthy Options. MAA contracts with seven managed care organizations (MCOs) in 38 of 39 counties. Enrollment is voluntary in eleven counties, either because there is only one MCO or because the contracted MCOs do not have sufficient capacity to accept new enrollees. There are no Medicaid providers in one rural county, and any Medicaid beneficiary must travel to an adjacent county for health care.

Four MCOs currently operate as non-profit companies serving both commercial and government (Medicaid and state-funded[3]) populations; one non-profit and two for-profit MCOs serve government programs exclusively.

A. Medical Assistance Administration Mission and Goals

The MAA mission is to maximize opportunities for low-income people to obtain quality health care and make fair, accurate and timely disability determinations. Led by this mission and aligned with the Assistant Secretary's strategic plan, MAA developed six-year goals. The 2004 through 2009 goals for managed care and fee-for service (FFS)[4] include:

- Enhance contracting capability with health carriers for the provision of health care services to families, pregnant women, and non-disabled children;
- Improve health service access, quality, care management, and service use for clients who are aged, blind, disabled, and on General Assistance-Unemployable benefits;

[3] Basic Health program for low income, working families, and Public Employees.
[4] The MAA payment method to reimburse providers for covered medical services provided to clients on medical assistance when those services are not covered under the Healthy Options program.

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- Improve the ability to be an effective purchaser of health services;
- Strengthen information and fiscal monitoring systems to better manage programs;
- Enhance the capability to accurately determine client eligibility; and
- Consolidate and integrate operations among other state agencies and within the department to enhance client services and be more cost effective.

B. Managed Care Organizational Structure

Five divisions in MAA assist the Assistant Secretary in carrying out the MAA mission. Managed care program administration is located in the Division of Program Support (DPS). The Division of Customer Support (DCS) collaborates with DPS to administer SCHIP. The Division of Medical Management (DMM) administers the quality program for both the managed care and FFS programs. The Information Services Division (ISD) provides information systems support for all MAA divisions. The Division of Policy and Analysis (DPA) provides overall legislative and policy support.

III. Quality Strategy Development and Review

The DMM Quality Assessment, Improvement and Monitoring (Q-AIM) section, in collaboration with the Managed Care Contracts section in DPS is responsible for developing the Quality Strategy. The DMM Medical Director, the DMM Deputy Director, and the DPS Division Director sponsor and approve the Quality Strategy. The objective of the quality strategy is to support the goals of MAA by creating the necessary infrastructure to fulfill the established standards for access to care, structure and operations, and quality measurement and improvement.

Development of the quality strategy involves the principles of the PDSA cycle (Plan, Do, Study, Act)[5]. Strategic planning for the quality strategy aligns work processes with MAA's goals and objectives (see above). Assessment includes identification of key stakeholders, enrollee characteristics, health care performance and operational requirements. MAA staff incorporate Healthy Options and Federal requirements and propose a monitoring strategy to the sponsors and executive leaders. Sponsors review the draft and initial approval is obtained from the Centers for Medicare and Medicaid Services (CMS) in DHHS, and MAA Executive Leadership (EL). Beneficiaries and other stakeholders are notified that the strategy is available for public comment on the DSHS and MAA website. After a 30-day public comment period, Q-AIM makes any needed changes, sponsors approve the strategy and it is submitted for final CMS approval and adoption by EL.

Q-AIM evaluates the overall effectiveness, updates the strategy periodically, and produces an annual report. The evaluation includes information about:

[5] The Plan, Do, Study, Act Model or PDSA cycle is a common model used for improving quality in health care.

- Progress and status of goals;
- Trends in clinical and service quality performance improvement programs;
- Corrective actions and sanctions;
- Progress and status of value based purchasing; and
- Overall structure and process of the Quality Strategy.

The report is submitted to sponsors, EL, and CMS. Beneficiaries and stakeholder groups may view annual reports on the MAA website. The strategy is also updated when MAA makes a material change in the strategic plan or when there is a significant change in the Healthy Options plan. For example, a governor mandate or legislative change that would trigger public comment, or a change in the quality strategy accountability or critical process. Significant changes to the Quality Strategy require CMS approval and adoption by EL.

IV. Managed Care Contract Standards

MAA incorporates the Quality Strategy in MCO contracts. MCO contract requirements include compliance with applicable Federal and State statutes and 42 CFR 438 including:

- Availability of Services, including emergency and post stabilization of services;
- Continuity and coordination of care;
- Provider selection;
- Enrollee information;
- Enrollee rights;
- Confidentiality and accuracy of enrollee information;
- Enrollment and disenrollment;
- Subcontractual relationships and delegation;
- Practice guidelines;
- Health information systems;
- Mechanisms to detect both under and over utilization of services;
- Quality improvement;
- Utilization management;
- Member services;
- Provider services;
- Record keeping;
- Access standards; and
- Data reporting.

Summary descriptions of MCO contract provisions, which are as stringent as and meet BBA requirements and are substantially consistent with DHHS monitoring protocols are described included in the quality strategy. MAA monitors MCO contracts to ensure compliance.

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A. Access to Care Standards

Medical advice is available 24-hours a day, seven days a week from licensed health care professionals. MCO contract requirements include compliance with the following appointment time standards and provider network distance standards in accordance with 42 CFR 438.206.

- Preventive care;
- Routine primary care;
- Urgent care;
- Emergency care;
- After-hour services (24 hours a day, seven days a week when medically necessary);[6]
- Telephone service (e.g., responsiveness of member services telephone lines and appointment telephone lines); and
- Number and geographic distribution of Primary Care Providers (PCPs) and specialty practitioners.

To ensure adequate capacity, MCOs may use of a wide variety of qualified practitioners as primary care providers (PCP), including Pediatricians, Family Practitioners, General Practitioners, Internists, Advanced Registered Nurse Practitioners and Physician Assistants (under the supervision of a physician). MCO contracts require MCOs to maintain and monitor their network of appropriate providers (42 CFR 438.206 (a)). They must consider:

- Anticipated enrollment;
- Expected utilization of services based on enrollee characteristics and health care needs;
- Numbers and types of network providers required to furnish contract services;
- Number of network providers who are not accepting new patients; and
- Geographic location of providers and enrollees (distance, travel time, means of transportation enrollees normally use, and physical access for enrollees with disabilities).

Individuals with Special Health Care Needs

Over eighty percent of the managed care clients are under the age of nineteen. MAA identifies special health care individuals as Title V eligible assigned by the Department of Health and through specific questions on the application for medical coverage: (1) Is a child under age 19 in your household disabled? (2) If "Yes" who? (3) Do you pay someone to take care of a disabled dependent adult while you work?

[6] The definition of Medically Necessary services in the 2003 *Healthy Options* contract is: services which are reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee requesting the service. For the purpose of this agreement, course of treatment may include mere observation or, where appropriate, no treatment. Medically necessary services include, but are not limited to, diagnostic, therapeutic, and preventive services.

This information is sent to the MCOs with monthly enrollment data. MAA annually reviews and evaluates detailed information regarding access to primary care, specialty care and overall coordination of care for individuals with special health care needs.

Contractual agreements with the MCOs require that primary care practitioners develop individualized care plans which integrate clinical and non-clinical disciplines and services into the overall plan of care. Grievances of enrollees with special health care needs are examined annually by the monitoring team, during a sample review of grievance files.

All Medicaid Enrollees, including Potential Enrollees, and Individuals with Special Health Care Needs

Enrollees are encouraged to choose a PCP. If one is not selected, the MCO assigns a PCP or clinic within a reasonable proximity to the enrollees' home, no later than fifteen (15) working days after coverage begins. To ensure each enrollee has an ongoing source of primary care, the PCP is responsible for provision, supervision, and coordination of health care to meet enrollee needs.

In the process of coordinating care, each enrollee's privacy must be protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

The MCO contract specifies the amount, duration and scope of services offered. Appendix A describes the services covered under the Healthy Options contract, plus the procedures and policies for authorization of services. Services covered under FFS are required covered services for Healthy Options. The MCO may establish utilization controls provided that medically necessary services are not denied. Medical necessity is defined in contract and in Washington State Administrative Code (WAC). Service authorizations require physician approval of denials for medical necessity.

Other MCO standards relating to access to care include:

- Direct access to a woman's health specialist for women's routine and preventative services (42 CFR 438.206 (b)(2));
- Second opinion from a qualified health care professional within the network or arrange for one outside the network at no cost to the enrollee (42 CFR 438.206(b)(3));
- Medically necessary services obtained outside the network if, and for as long as, they cannot be obtained within the network (42 CFR 438.206 (b)(4)), and payment coordination with out-of-network providers to ensure cost to the enrollee is no more than it would be if the services were provided within the network (42 CFR 438.206 (b)(5));
- Network provider hours of operation that are no less than those offered to commercial enrollees or comparable Medicaid FFS, if the provider serves only Medicaid enrollees (42 CFR 438.206 (C)(1));

- Delivery of culturally competent services to enrollees with limited English proficiency and diverse cultural and ethnic backgrounds (42CFR 438.206 (c)(2)); and
- Interpreter services available free of charge to enrollees.

B. Structural and Operational Standards

Extensive and specific standards for provider selection and retention, physician incentive plans, credentialing and recredentialing policies and procedures, documentation requirements to ensure confidentiality and other requirements (e.g., Section 1128 or 1128A of the Social Security Act) are detailed in the MCO contract:

- Prohibit contracting with individual practitioners or providers with ownership or controlling interests in an MCO or convicted of crimes;
- Compliance with all Federal and Healthy Options nondiscrimination laws and regulations, including non-discrimination against providers serving high risk populations or specializing in conditions that require costly treatment (42 CFR 438.214);
- Consider provider training, experience, and specialization to ensure experience in treating enrollee conditions (42 CFR 438.206 (b)(1)(iii));
- Compliance with MAA credentialing and recredentialing policies outlined in the MCO contract, including incorporating information from enrollee complaints and QI activities in practitioner credentialing activities (42 CFR 438.214 (b)); and
- Disclosure and approval of any physician incentive plan prior to implementation.

Eligibility for Medicaid is determined by the Community Services Offices (CSOs). The information is entered into a client eligibility system which passes information to MAA's billing and eligibility system. Enrollees eligible for Medicaid coverage and are in a medical program covered by Healthy Options receive enrollment and health plan selection material to assist in choosing a health plan and provider.

Contract requirements and specifications relating to enrollee information are found throughout the Healthy Options contract. MCOs submit enrollee material for MAA contract manager's approval. The material is reviewed using a checklist composed of Healthy Options and Federal requirements. Deficiencies are returned to the MCO for correction and tracked for compliance.

MCO contract requirements for enrollee information include:

- Sixth grade reading level for all enrollee materials;
- Alternative format and language requirements (42 CFR 438.10);
- Enrollee handbooks to include information on grievances, appeals and denials, benefit coverage, and how to obtain care;
- Advance directives; and
- Written notice of termination of a contracted provider.

The MCO contract specifies how and why an enrollee may be disenrolled for cause. In addition to exceptions determined by MAA case-by-case, reasons enrollees may be disenrolled include:

- Foster care;
- A medical need that requires continuation of an established treatment plan;
- Accessible third-party insurance;
- American Indian or Alaskan Native;
- Homeless;
- Special health care needs;
- Language barriers; and

Confidentiality requirements in the contract govern disclosure of medical records and other health information that individually identifies an enrollee in accordance with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) regulations and 42 CFR 438.224.

MAA requires each MCO to have a grievance system that meets 42 CFR 438.228. Comprehensive standards in the contract include:

- Enrollee right to file a grievance or appeal, receive assistance (e.g., interpreter services and toll-free numbers), and contribute to and participate in appeal hearings;
- Specified timelines for enrollee appeals and MCO response;
- Individuals making decisions have appropriate clinical expertise and are not involved in previous levels of review;
- Easily understood enrollee communication written in the enrollee's primary language, giving clear explanation of the action and reasons, circumstances for and how to request expedited resolution, right to continue benefits pending appeal resolution, how to request it, circumstances under which enrollees may be required to pay, and written notice of resolution and completion date;
- Enrollee right to request an MAA fair hearing after exhausting all levels of the MCO grievance and appeal system. The entire appeal process, including MAA fair hearing, must be completed within 90 calendar days of the date the enrollee filed the appeal with the MCO;
- Maintain a record of all actions, grievances, and appeals and submit a complete report to MAA twice a year;
- Treat enrollee oral inquires seeking to appeal an action as appeals and confirm in writing, unless the enrollee or provider requests an expedited resolution;
- Enrollee opportunity to present evidence in person or in writing, and examine medical records and other documents considered in the appeal; and
- Include the enrollee and the enrollee's representative or estate as parties to the appeal.

Enrollees may communicate grievances to MAA. Exception Case Management (ECM) staff in the Division of Customer Support (DCS) receive grievances through the MAA phone hotline for both FFS and Healthy Options. Grievances involving an MCO are forwarded to the Division of Program Support contract manager, who works to resolve

the issue. ECM sends grievances with a known or possible clinical component to Division of Medical Management (DMM) clinical staff for assessment and recommended disposition. Grievance information and resolutions are entered on the Complaint Management Information System (CMIS) database for tracking, analysis and quality measurement or improvement activities.

To ensure protection of enrollee rights, contract managers approve each MCO grievance process. The team verifies that processes approved are operational by assessing compliance with Federal and State regulations and National Committee for Quality Assurance (NCQA) standards in a review of a sample of MCO grievance and appeal files (including Independent Review Organization appeals). Areas assessed include actions based on medical necessity, timeliness, and actions taken and outcomes in identified problematic patterns of under and over-utilization. Compliance scores are incorporated in the quality report.

Subcontractual relationships and delegation standards meet the conditions of 42 CFR 438.20. On a yearly basis, MAA contract management staff review Healthy Options Contractor subcontracts and delegation agreements using an established checklist. The review ensures that all subcontract elements required in the Healthy Options contract and regulations are included in subcontracts and delegation agreements. If an item on the checklist is not met, the MCO is required to correct missing or incorrect information.

During MAA's yearly contract compliance audit of MCOs, three (3) different types of fully executed subcontracts are reviewed. If the subcontract language does not meet established requirements, the MCO is required to submit a corrective action plan. Amendments to the subcontracts are usually required to address problems identified through the review process. Examples of the subcontract and delegation agreement requirements examined in the subcontract and delegation agreement review include:

- Solvency;
- Procedures and specific criteria for termination of the contract;
- Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor;
- Reimbursement rates and procedures for services provided under the subcontract;
- Reasonable access to facilities and financial and medical records for duly authorized representatives of MAA for audit purposes, and immediate access for Medicaid fraud investigators;
- Completely and accurately report encounter data to MAA;
- Compliance with the approved fraud and abuse policies and procedures;
- A quality improvement system tailored to the nature and type of services subcontracted, which affords quality control for the healthcare provided, including but not limited to the accessibility of medically necessary care, and which provides for a free exchange of information with the MCO to assist in quality improvement efforts;
- A ninety (90) day termination notice provision; and
- A specific termination provision for termination with short notice when a provider is excluded from participation in the Medicaid program.

C. Quality Measurement and Improvement Standards

With permission, MAA incorporates most of the NCQA quality standards in MCO contracts. Nationally, and in Washington State, increasing evidence suggests MCOs have achieved better outcomes in the quality of care and services since regular monitoring of MCO quality standards.[7] MAA reviews the required quality standards with MCO contract renewal and revises them as necessary to ensure standards are not in conflict with Healthy Options or Federal statute or regulation. Quality standards in the MCO contract include:

1. Clinical Practice Guidelines

MAA requires MCOs to utilize clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. The language concerning clinical practice guidelines is in the Healthy Options contract. Monitoring the guidelines for contract compliance is part of the yearly review process. The MCOs must:

- Consider enrollee needs, and in consultation with contracted health care professionals, adopt clinical practice guidelines based on valid and reliable clinical evidence, and disseminate to all affected providers and enrollees upon request;
- Annually measure performance against the guidelines and review and update the guidelines periodically; and
- Ensure utilization management decisions, benefit coverage, enrollee education materials, and disease management programs are consistent with the guidelines.

The MCO must annually measure performance against at least three clinical practice guidelines, using at least two important aspects of care.

2. Performance Measurement

MAA participates in the Performance Measurement Partnership Project, a collaborative effort between Federal and Healthy Options officials to develop national Medicaid and SCHIP performance measures. The purpose is to recommend national performance measurement standards for the quality of health care to CMS. When final, CMS performance measures are required to be in the quality strategy and in contract language. Contract language relating to performance measurement includes:

- Annually collect and submit audited HEDIS®[8] performance measures selected by MAA.

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[7] For the past five years, NCQA has found that among commercial health plans, individuals enrolled in NCQA-Accredited Medicare and Medicaid health plans receive significantly better care than those enrolled in non-accredited health plans. *The State of Health Care Quality, 2002*.

[8] Health Plan Employee Data and Information Set, is a registered trademark of NCQA.

3. Quality Assessment and Performance Improvement Program

MAA requires each MCO to have a quality improvement program. Yearly assessment of the impact and effectiveness of the program is conducted. Healthy Options contract language requires MCOs to:

- Maintain an ongoing quality assessment and performance improvement (QAPI) program that meets the quality standards incorporated in the contract;
- Maintain an ongoing program of performance improvement projects (PIPs) in clinical and non-clinical areas designed to have a favorable effect on health outcomes and enrollee satisfaction and achieve significant improvement, sustained over time through ongoing measurement and intervention;
- Use data and information provided by MAA to identify and correct problems and improve enrollee health care and services, including use of external quality review findings, audits and contract monitoring activities, HEDIS and Consumer Assessment of Health Plans Survey (CAHPS®) results, and enrollee grievances;
- Have mechanisms to detect both underutilization and overutilization; and
- Assess the quality and appropriateness of care furnished to enrollees with special health care needs.

4. Performance Improvement Projects

MCOs are required to implement several performance improvement projects designed in accordance with 42 CFR 438.240, such as Well Child visits, Immunizations, CAHPS[9]. MCOs are required to report the status and results of their improvement projects annually. In-depth monitoring of intervention effectiveness is done during annual reviews. Performance improvement projects are designed to:

- Assess MCO population and focus on clinical and non-clinical areas relevant to Medicaid;
- Measure performance using objective quality indicators;
- Implement interventions designed to achieve improvement in the areas of focus;
- Evaluate the effectiveness of the interventions;
- Plan and initiate activities to increase or sustain quality improvement; and
- Complete PIP in a reasonable time period that allows aggregate information to produce new information on quality every year.

5. Health Information Systems

Two DSHS administrations, Economic Services Administration (ESA) and MAA collect and process information to support the ongoing operations of the quality strategy (42 CFR 438.204(f)). CSOs determine eligibility for Medicaid and collect client demographic data, including primary language and special needs. The eligibility information system is linked to the MAA Medicaid Management Information System

[9]Commercial and Medicaid survey designed to collect an enrollee's experience of health care based upon their health insurance.

(MMIS), which includes fee-for-service (FFS) medical claims and managed care encounter data. Reports and data from the MMIS system supports the quality strategy by providing encounter and emergency room utilization data, trends, and performance indicators.

MAA requires each contracted MCO to:

- Maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the standards, information and performance reporting requirements, and objectives of the BBA;
- Maintain records and information on utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility (42 CFR 438.242(a)), and regularly review the information (42 CFR 438.416);
- Collect data on enrollee and provider characteristics and services furnished to enrollees through an encounter data system and data fields specified by MAA;
- Identify special conditions that require treatment or regular monitoring and assess the quality and appropriateness of care for enrollees with special health care needs;
- Ensure that data received from providers are accurate and complete by verifying the accuracy and timeliness of reported data (42 CFR 438.242 (b) (2) (i)) and (42 CFR 438.606), screening data for completeness, logic, and consistency (42 CFR 438.242 (2) (ii)), and collecting service information in standardized formats to the extent feasible and appropriate (42 CFR 438.242(2) (iii));
- Make all collected data available to MAA and upon request to CMS (42 CFR 438.242(3)) and certify all payment-based data and documentation by the CEO, CFO, or an individual who reports to and has delegated authority to sign for them (42 CFR 438.606);
- Conduct and submit to MAA periodic information systems capability reports;
- Report the status of physician incentive plans as requested by MAA; and
- Ensure subcontractors comply with all information system requirements the MCO is required to meet.

V. MAA Quality Monitoring and Evaluation

MAA through the use of desk audits and onsite reviews monitors and evaluates MCO compliance with standards for access to care, structure and operations, and quality measurement and improvement. Desk audits are ongoing, and onsite reviews are yearly. Onsite reviews generate MCO comparison reports.

A. Ongoing monitoring

DPS contract managers monitor compliance with structural and process standards through ongoing desk review of policies and procedures, including grievances, fraud and abuse, credentialing, and claims payment. They approve all MCO enrollee materials using a standardized checklist to assess content and reading level, communication of enrollee rights and responsibilities, and compliance with privacy and confidentiality policies.

Contract managers also approve MCO provider subcontracts and delegation agreements annually to ensure all elements required in the MCO contract affected by the delegation are included in subcontracts and agreements.

The MCO is required to correct deficiencies and MAA tracks corrective actions to ensure compliance.

B. Annual review

An interagency, multidisciplinary team,[10] which consists of representatives from MAA, Health Care Authority (HCA), and the Department of Health (DOH), conducts annual reviews to assess MCO operations, using standardized interview, observation, and document review methods of evaluation. For example, the team examines three types of fully executed subcontracts during on-site reviews to verify that MCOs are using the templates contract managers approved in desk audits. The team scores each standard on an evaluation tool based on assessment of compliance with critical elements. The evaluation tool uses the DHHS monitoring protocol with added NCQA and MAA standards.

A compliance report is sent to each MCO. The reports are available to the public. The Corrective actions required for follow up by either contract managers or the monitoring team are tracked. Q-AIM uses the scores in analytical activities and to inform procurement.

Standards reviewed on-site may vary from year to year based on analysis of individual MCOs (which may generate a targeted review), statewide issues, or a particular subject area of focus.

C. Grievances

MAA staff annually review MCO policies and procedures for authorization of services, including handling of actions, grievances and appeals to ensure compliance with Federal and Healthy Options regulations and established standards. Samples of thirty (30) denial actions, thirty (30) grievances, and thirty (30) appeal files are reviewed using standards for documentation and resolution. Among the action and denial standards reviewed for compliance are:

- A physician's review of utilization management medical necessity actions;
- Actions processed within decision time standards;
- Content of written materials written in easily understood language and at 6th grade level, and provide the enrollee their appeal rights;
- Instructions on how to obtain the clinical review criteria for decision-making; and
- Clinical information appropriate to support the action decision.

[10] A team of experienced reviewers, responsible for monitoring MCO compliance with standards for health care quality management, provider access and availability, credentialing, utilization management including enrollee grievances and appeals, and applicable federal and state laws.

Among the grievance standards reviewed are:

- Adequacy of grievance documentation;
- Timeliness of grievance resolution such as evidence of informing enrollees in writing with fifteen (15) days of enrollment; and
- Evidence that the MCO investigated the grievance, and notified the member of the grievance resolution, including appeal rights if applicable.

Among the appeal standards reviewed are:

- Documentation of the appeal;
- Investigation of the appeal, i.e., consideration of any additional information provided by the member or requesting practitioner and assessment of additional information that was not considered when the MCO first made its decision;
- Different medical reviewer for each level of appeal and review by the same or similar specialist; and
- Notification of the enrollee's right to appear in person, representation at the appeal hearing or the ability to communicate with the appeal panel.

MCOs are given performance ratings on each standard based on the review of action, grievance, and appeal files. Each file is scored against the standards and a cumulative score or rating is calculated based on the review.

MCOs are required to submit a corrective action plan to MAA for any standard with a rating below 90 percent. Systemic problems identified through the review process, such as understandability of the action (or denial) letter content are remedied through consultation assistance or the development of a common set of letter templates provided by MAA for use by the MCOs.

D. Access

Medicaid eligibility is determined by Community Services Offices (CSOs). The CSO eligibility data system is linked to the MAA Automated Client Eligibility System (ACES), which is linked to the MAA Medicaid Management Information System (MMIS). The MMIS includes FFS claims for payment and managed care premium payments. Managed care encounter data are processed and stored in separate extract files. The MAA Information Services Division (ISD) maintains the extract files and monitors MCO data for accuracy and completeness.

To help with choosing an MCO, MAA sends every person eligible for its Medicaid managed care program coverage individualized enrollment materials, including an MCO enrollment form, MCO information for the potential enrollee's service area, consumer survey and clinical performance measure results, a Healthy Options handbook, and a cover letter.

Each month MAA sends enrollment information completed by the client to the MCO the enrollee chooses in order to help the MCO provide continuity and coordination of care. Enrollees may request to be taken out of managed care (disenrollment). When approved by Exception Case Management (ECM) staff, the enrollee is transferred to FFS. MAA collects disenrollment information on the Contract Management Information System (CMIS) database.

MAA also sends enrollment materials to potential enrollees in voluntary counties who may choose FFS. These materials include a guidebook explaining the FFS option, the type of benefits provided, and the choice of retaining an established PCP (if the PCP accepts Medicaid payments).

E. Credentialing

MAA ensures compliance with practitioner standards through review of MCO mechanisms for credentialing and re-credentialing contracted or employed practitioners, including sanctioning history. Documents reviewed include provider survey reports, minutes from credentialing committees, definition of the scope of practitioners covered, criteria and primary source verification, and decision-making policies.

The on-site review compares MCO policies and procedures with their operations, including methods to assess adequacy of primary care and specialty care access, and the steps taken to correct access problems where identified. Review of samples of executed provider agreements and practitioner credentialing files, and crosscheck with the National Practitioner Data Bank (NPDB) for sanctions or licensure limitations provides further assurance of compliance.

F. Quality Improvement Program

The MCO contract requires PIPs for select HEDIS measures when the MCO rate is below the performance rate specified in the MCO contract. The contract also requires specific improvement projects for CAHPS® rates below the performance rate specified, using the National CAHPS Benchmarking Database (NCBD). CAHPS data are published annually.

In annual reviews, the monitoring team reviewers experienced in quality improvement examine the MCO quality program, including practitioner availability and accessibility, clinical practice guidelines,[11] continuity and coordination of care, HEDIS clinical performance measures, performance improvement activities (such as Childhood Immunizations and Well Child Care Visits) and the effectiveness of the MCO QAPI program, including performance on required performance measures and results of each PIP. Reviewers also assess the MCO's own evaluation of its quality program.

Review of the quality program includes use of preventive health guidelines and disease management programs (such as high risk pregnancy, asthma, diabetes, etc.), care

[11] Clinical practice guidelines are based on clinical evidence, adopted in consultation with contracting health care providers, reviewed and updated periodically, and applied to individuals based on needs.

coordination or case management programs for enrollees with special health care needs, and communication about these programs to enrollees and practitioners. Other standards reviewed in the quality program include utilization management, information systems, and medical record documentation standards and confidentiality policies and procedures.

The encounter data system and decision support system software enable queries to identify utilization of services. Quality and appropriateness of care, and discrimination among enrollees is monitored by actual chart review. The monitoring team currently conducts these activities during reviews of the MCO's quality, utilization, and information systems and management reports.

Q-AIM analyzes statewide HEDIS performance data and publishes an annual report with individual MCO rates, statewide and regional aggregate rates, comparative and longitudinal data and national benchmarks.

The HEDIS® audit is conducted by an independent NCQA certified auditor. The audit assesses MCO information system characteristics and capability to accurately process and report medical, member, and practitioner information. The audit also verifies that MCO processes conform to HEDIS® technical specifications. Independent auditing enables MAA and MCOs to rely on the data for quality activities and meets DHHS independence and competence requirements for performance measure validation.

To emphasize improvement on specific clinical measures important to the Assistant Secretary and national initiatives, DMM and DPS developed and EL approved a new quality incentive, value based purchasing (VBP), scheduled for implementation on January 1, 2004. The initiative includes three HEDIS® Effectiveness of Care measures with quality adjustors for attaining rates above an established performance target. Since HEDIS rates are based on prior year data, the quality adjustor calculated in 2004 is provided to MCOs for information only. An actual monetary quality adjustor is applied to the 2005 HEDIS rate (based on services provide in the 2004 calendar year). The scope of VBP is expected to broaden as results are evaluated and better quality encounter data become available. The VBP initiative also includes non-financial incentives and disincentives, such as:

- Rotation of required performance measures;
- Increased enrollee assignments (if the MCO wishes);
- Publication of performance rates in highly valued media;
- Increased compliance reviews or audits; and
- Additional required quality improvement projects.

G. Sanctions

VBP non-financial incentives can be viewed as sanctioning. In addition, sanctions, including withholding up to five percent of MCO payment and withholding enrollee assignments, may be authorized if a MCO:

- Fails to provide medically necessary services;
- Imposes enrollees premiums or charges;

- Discriminates among enrollees;
- Misrepresents or falsifies information;
- Fails to comply with requirements for physician incentive plans;
- Distributes unapproved marketing material; and
- Violates any other requirements of sections 1903(m) or 1932 of the Social Security Act.

Before imposing sanctions the MCO is notified in writing of the nature of the default and given a reasonable deadline to respond. If the MCO requests a dispute resolution, MAA may withhold payment until the default is resolved or the dispute is resolved in favor of the MCO.

VI. External Quality Review

The BBA requires each Healthy Options Medicaid agency contracting with MCOs to ensure a qualified external quality review organization (EQRO) performs an annual external quality review (EQR) of MCO required PIPs and required performance measures, and conducts a review of compliance with standards within a three-year period. MAA is responsible for ensuring the EQRO has sufficient information to perform an annual EQR for each MCO (42 CFR 438.350). The contract scope includes the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to health care services that an MCO, or their contractors furnish to Medicaid recipients.

The Healthy Options contract requires MCOs to allow a qualified EQRO, contracted by MAA, to perform an annual external independent review as described in 42 CFR 438.358.

MAA or the EQRO may use information obtained from a Medicare or private accreditation review of an MCO to avoid duplication, when all of the following conditions are met (42 CFR 438.360):

- The MCO is in compliance with standards established for Medicare MCOs or NCQA;
- Compliance is determined by CMS, its Medicare contractor, or NCQA;
- The standards are the same or substantially comparable to those in the Healthy Options contract;
- The MCO provides MAA with all the reports, findings, and other results of the Medicare or NCQA accreditation review, and MAA provides the information to the EQRO; and
- MCO requirements or standards not included in Medicare or NCQA reviews are evaluated separately by MAA, or the MCO has achieved a designated score on those standards for the two previous years in MAA reviews.

MAA provides copies of EQR information, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees, recipient advocacy groups, and members of the general public.

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VII. Race, Ethnicity and Primary Language

Enrollees self identify race,[12] ethnicity, and primary language[13] on the Medicaid application in CSOs which are part of the Economic Services Administration. This information is passed to MAA utilizing compatible computer systems. Race and ethnicity categories are consistent with standard categories developed by the Bureau of Census and are commonly used throughout the state to collect race and ethnicity data.

At the time of enrollment (42 CFR 438.204 (b) (1)) MAA sends identifiers of enrollee's race, ethnicity, prevalent non-English spoken language (42 CFR 438.10 (c) (1)) and children with special health care needs (42 CFR 438.208 (c) (1)) to each MCO on a monthly basis.

If Supplemental Security Income (SSI) enrollees become eligible for SSI after enrollment in Medicaid, the information is entered into the electronic eligibility database.

VIII. Summary

The MAA Quality Strategy provides a description of the managed care quality program, including standards for safe, effective, quality health care. MCO contracts include information on the monitoring process, protocols, and strategies MAA uses to ensure compliance with the standards, and a description of how MAA complies with BBA requirements, including external quality review.

The annual report is submitted to sponsors, executive leadership and CMS. Based upon the annual evaluation, a plan is developed to guide and focus work for the following year. Thus, MAA uses the information obtained through monitoring and evaluation activities to improve the quality program for Medicaid managed care in Washington and achieve the mission of attaining better health for our most vulnerable residents.

[12] White, Black or African American, Asian, Native Hawaiian or other Pacific Islander, Hispanic or Latino, and Other.

[13] Questions include: Do you have trouble speaking, reading or writing English? Do you need materials sent to you in another language? Do you need an interpreter? (If yes, we will help you through an interpreter). What language do you speak?

Appendix A
MCO Scope of Services

The MCO must cover the services described below when medically necessary. The amount and duration of covered services that are medically necessary depends on the enrollee's condition.

The scope of covered services is generally comparable to the DSHS Medicaid fee-for-service program. Enrollees have the right to self-refer for certain services to providers paid through separate arrangements with the state of Washington. The MCOS are required to inform enrollees, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. The services to which an enrollee may self-refer are:

- Outpatient mental health services to community mental health providers of the DSHS Mental Health Division, Regional Support Networks (RSN);
- Family planning services and sexually transmitted disease screening and treatment services provided at family planning facilities;
- Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through the local health department; and
- Medical services provided to enrollees who have a diagnosis of alcohol and/or chemical dependency are covered when those services are otherwise covered services.

Inpatient and outpatient services provided by acute care hospitals (licensed under RCW 70.41), or nursing facilities (licensed under RCW 18-51) when nursing facility services are not covered by the DSHS Aging and Disability Services Administration and the MCO determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included. MCOs must cover emergency and post-stabilization services as described below:

- All inpatient and outpatient emergency services in accord with the requirements of 42 CFR 438.114;
- All emergency services provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider;
- Emergency services shall be provided without requiring prior authorization; and
- What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 CFR 438.114 (d)(i)).

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The MCO shall cover treatment obtained under the following circumstances:

- An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition;
- A plan provider or other MCO representative instructs the enrollee to seek emergency services;
- If there is a disagreement between a hospital and the MCO concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the MCO.

The MCO is required to cover post-stabilization services as defined below:

- All inpatient and outpatient post-stabilization services in accord with the requirements of 42 CFR 438.114 and 42 CFR 422.113(c);
- All post-stabilization services provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider.

The MCO is required to cover post-stabilization services under the following circumstances:

- The services are pre-approved by a plan provider or other MCO representative;
- The services are not pre-approved by a plan provider or other MCO representative, but are administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCO for pre-approval of further post-stabilization care services;
- The services are not pre-approved by a plan provider or other MCO representative, but are administered to maintain, improve, or resolve the enrollee's stabilized condition; and
- The MCO does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d));
- The MCO cannot be contacted.
- The MCO's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a MCO physician is not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with a MCO physician and the treating physician may continue with care of the enrollee until a MCO physician is reached or one of the criteria below is met.

The MCO's responsibility for post-stabilization services it has not pre-approved ends when:

- A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A participating provider assumes responsibility for the enrollee's care through transfer;
- A MCO representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.

MCO's must cover services provided at ambulatory surgery centers.

Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, and certified dietitians.

Provider services include, but are not limited to:

- Medical examinations, including wellness exams for adults and Early Periodic Screening, Diagnostic and Treatment (EPSDT) for children;
- Immunizations;
- Maternity care;
- Family planning services provided or referred by a participating provider or practitioner;
- Performing and/or reading diagnostic tests;
- Private duty nursing;
- Surgical services;
- Surgery to correct defects from birth, illness, or trauma, or for mastectomy reconstruction;
- Anesthesia;
- Administering pharmaceutical products;
- Fitting prosthetic and orthotic devices;
- Rehabilitation services;
- Enrollee health education;
- Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia;
- Nutritional counseling when referred as a result of an EPSDT exam;
- Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, and peripheral blood stem cell;
- Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy;
- Vision Care: Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The MCO may restrict non-emergent care to participating providers. Enrollees may self-refer to participating providers for these services.

Outpatient mental health service are covered as follows:

- Psychiatric and psychological testing, evaluation and diagnosis:
  - Once every twelve (12) months for adults twenty-one (21) and over; and
  - Unlimited for children under age twenty-one (21) when identified in an EPSDT visit.

- Unlimited medication management:
  - Provided by the PCP or by PCP referral;
  - Provided in conjunction with mental health treatment covered by the MCO;
  - Twelve hours per calendar year for treatment; and
  - Transition to the RSN, as needed to assure continuity of care, when the enrollee has exhausted the benefit covered by the MCO or when enrollee requests such transition.

- Referrals To and From the RSN:
  - The MCO shall cover mental health services provided by the RSN, up to the limits described herein, if the MCO refers an enrollee to the RSN for those services;
  - The MCO may, but is not required to, accept referrals from the RSN for the mental health services described herein;
  - The MCO may subcontract with RSNs to provide the outpatient mental health services that are the responsibility of the MCO. Such agreements shall not be written or construed in a manner that provides less than the services otherwise described in this section as the MCO's responsibility for outpatient mental health services.

Occupational therapy, speech therapy, and physical therapy services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability.

Prescription drug products are covered according to a MAA-approved formulary, which includes both legend and over-the-counter (OTC) products. The MCO's formulary shall include all therapeutic classes in the MAA fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet medically necessary health needs. The MCO provides participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs. The MCO shall approve or deny all requests for non-formulary drugs by the business day following the day of request.

Covered drug products include:

- Oral, enteral, and parenteral nutritional supplements and supplies, including prescribed infant formulas;
- All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies; including but not limited to Depo-Provera, Norplant, and OTC products;

- Antigens and allergens;
- Therapeutic vitamins and iron prescribed for prenatal and postnatal care.

Home health services are covered through state-licensed agencies.

Durable medical equipment (DME) and supplies that include, but is not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the enrollee agrees.

Oxygen and respiratory services: Oxygen, and respiratory therapy equipment and supplies.

Hospice services when the enrollee elects hospice care.

Blood, blood components and human blood products: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products the MCO shall cover the cost of the blood or blood products.

Treatment for renal failure such as hemodialysis or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

Ambulance transportation: The MCO covers ground and air ambulance transportation for emergency medical conditions, as defined herein, including, but not limited to, Basic and Advanced Life Support Services, and other required transportation costs, such as tolls and fares. In addition, the MCO shall cover ambulance services under two circumstances for non-emergencies:

- When it is necessary to transport an enrollee between facilities to receive a covered services; and,
- When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

Chiropractic services are covered for children when they are referred during an EPSDT exam.

Neurodevelopmental services are covered when provided by a facility that is not a DSHS recognized neurodevelopmental center.

Smoking cessation services are covered for pregnant women through sixty (60)days post pregnancy.

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